MDR Tracking Number: M2-03-1444-01
IRO Certificate# 5259

August 1, 2003

An independent review of the above-referenced case has been completed by a medical physician [board certified] in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY
This is a gentleman who on ___ sustained a lumbar injury. Various treatment modalities were attempted, however, this came to surgery and a lumbar fusion was completed. The fusion healed solidly. The primary treating physician noted a normal examination and declared maximum medical improvement. This went to a Designated Doctor for an additional endorsement of maximum medical improvement. Post primary treating physician and Designated Doctor assessment, a request was made to purchase the requested device. This went to another provider who also rejected the request. On March 17, there is a progress notes with no mention of the device. On April 22 there is a vendor generated progress notes, signed by the primary treating physician to endorse the use of the device. There is no discussion of specific utilization or efficacy of the device.

REQUESTED SERVICE (S)
Purchase RS4i stimulator

DECISION
Endorse the prior decision

RATIONALE/BASIS FOR DECISION
The primary treating physician failed to produce any competent, objective, and independently confirmable medical evidence-demonstrating efficacy of this device. The utilization curve is not documented and there is no measurable improvement in this condition. Has the use of oral analgesic been reduced? There is no data to indicate that is the case. Clearly there is no established positive result from the use of this device.
Moreover, there is no clinical assessment made by the primary treating physician that would support the use let alone the purchase of this device.

Lastly, this is a passive device and noting the date of injury, this claimant should be doing only those active modalities that enhance the rehabilitation of this injury. The proposed device is not broadly accepted as the prevailing standard of care and is not recommended as medically necessary. Such passive modalities are indicated in the acute phase of care and their use must be time limited. The Philadelphia Panel Physical Therapy Study found little or no supporting evidence to include such modalities in the treatment of chronic pain greater than 6 weeks. Moreover, the efficacy of this type of device in the long-term patient has been studied repeatedly. As noted by Herman (Spine 1994 Mar 1; 19(5); 561) this treatment adds no apparent benefit. Lastly as described by Deyo (NEJM 1990 Jun 7(23): 127-34) TENS is no more effective than placebo. The literature of blinded peer-reviewed studies does not support the efficacy of this device. This device does not improve the situation, there is no identification of a decrease in medication use and the functionality of the claimant was not reported out. The pathology is in the disc; the current talked about does not reach the level of the pathology. Lastly, the progress notes of the primary treating physician indicate a well healed wound and the surgical intent was reached. There is no discussion in the progress notes of the use of this device only the boilerplate vendor distributed document. The primary treating physician offers no clinical indication for the use of this device.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©)

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3)

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 4th day of August 2003.